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DOI:

[10.1111/1467-9566.13234](https://doi.org/10.1111/1467-9566.13234)

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Document Version

Peer reviewed version

Citation for published version (Harvard):

Williams, I, Harlock, J, Robert, G, Kimberly, J & Mannion, R 2021, 'Is the end in sight? A study of how and why services are decommissioned in the English National Health Service', *Sociology of Health and Illness*, vol. 43, no. 2, pp. 441-458. <https://doi.org/10.1111/1467-9566.13234>

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Journal:	<i>Sociology of Health & Illness</i>
Manuscript ID	SHI-00110-2020.R1
Manuscript Type:	Original Article
Subject Area:	Finance, funding, budgeting < RESEARCH AREAS, Health care systems < RESEARCH AREAS, Health service organisations < RESEARCH AREAS, Health systems < RESEARCH AREAS
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Is the end in sight? a study of how and why services are decommissioned in the English National Health Service

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Abstract

The decommissioning of a health care service is invariably a highly complex and contentious process which faces many implementation challenges. There has been little specific theorisation of this phenomena, although insights can be transferred from wider literatures on policy implementation and change processes. In this paper, we present findings from empirical case studies of three decommissioning processes initiated in the English National Health Service. We apply Levine’s (1979) typology of decommissioning drivers and insights from the empirical literature on pluralistic health care contexts, complex change processes, and institutional constraints. Data include interviews, non-participant observation and documents analysis. Alongside familiar patterns of pluralism and political partisanship, our results suggest the important role played by institutional factors in determining the outcome of decommissioning processes, and in particular the prior requirement of political vulnerability for services to be successfully closed. Factors linked to the extent of such vulnerability include the scale of the proposed changes and extent to which they are supported at the macro level.

Keywords

Health care decommissioning; health care reorganisation; case studies; health system change; disinvestment; health policy

Introduction

Financial and other resources are required for the introduction and spread of innovations in health services. One means of freeing up resources is the decommissioning of established services. History suggests, however, that the case for adoption of new services often proves more politically expedient than proposals to terminate existing ones, and planned processes of decommissioning are frequently unsuccessful on their own terms (Pierson 1994; Harris et al. 2011; Harlock et al. 2018). Although governments, service planners and (to a lesser extent) scholars have wrestled with this challenge, there is very little evidence to inform decommissioning policies. This is perhaps not surprising as decommissioning closely resembles other system change processes known to be complex and hard to predict, and this is intensified by the additional agitation provoked by *withdrawal* of treatments, services and organisations (Robinson et al., 2011). In this paper we address the question: what factors and processes facilitate the implementation of decisions to decommission services? We present empirical findings from longitudinal, prospective case studies of three decommissioning projects carried out in the English National Health Service (NHS) in the period 2014-2016. We begin with an analysis of gaps in knowledge, and a description of the theoretical frameworks and constructs that helped shape the research design and data analysis. These include a typology of decommissioning drivers from the cutback management literature (Levine, 1979), and insights from the empirical literature on pluralistic health care contexts, complex change processes, and institutional constraints. These provide reference points for analysis of the case study findings as they relate to our interest in the processes and factors influencing decommissioning implementation.

The drivers of decommissioning

Health care interventions and services can be decommissioned 'passively'; for example medicines may simply fall out of common usage, or services can be incrementally starved of resources until they become, in practical terms, inoperative.

In this paper, our interest is in 'active' decommissioning whereby deliberate and intentional decisions are taken with explicit accompanying actions intended to bring about the removal, replacement or reduction of health services (Williams et al., 2017). Decommissioning can take many forms, creating a 'dependent variable problem' for researchers (Green-Pedersen, 2004). In health care, much of the literature has concentrated on the case for decommissioning of medical interventions such as tests and treatments (Hasson et al. 2019). By comparison, service withdrawal through, for example, organisational closure, termination of contracts and reorganisation, is less well studied. This empirical discrepancy is reflected in a theoretical preoccupation with individual psychological and interpretative biases, and with how these disincline patients and practitioners towards decommissioning— for example through the much-cited concept of 'loss aversion' (Kahneman and Tversky 1979; Gupta et al. 2017). Broader institutional and social considerations are often relegated to the role of secondary variables in this predominantly behavioural paradigm (Patey et al., 2018). Meanwhile, much of the organisational studies tradition neglects the decline phase and the impact of downsizing on, for example, workforce (Quinn and Cameron 1983; Vahtera et al. 2004). Overall then, understanding of organisational withdrawal and closure remains limited, especially in the health care arena (Williams, 2015).

An exception to this is the work of Levine (1978; 1979) whose examination of managerial responses to financial deficits in public organisations included what he described as a 'crude scheme' for categorising the causes of organisational decline (1978: 318). This contained four causal types, with three emanating from political and economic contexts, and the fourth from organisational behaviours. The first cause is termed problem depletion and refers to reductions in the perceived necessity and importance of the organisation's mission, in the context of wider social and demographic changes. To illustrate, Levine invokes the example of the widespread deinstitutionalisation of psychiatric care in favour of new service models. The second driver – environmental entropy – is caused by economic decline, and results in decrements to public sector budgets and consequent threats to the financial viability of individual organisations. The organisational effects of this environmental entropy can be indiscriminate or, as Levine notes, regressive: 'the forced choice of cutting services to an ever more dependent and needy population is the cruel outcome of decline' (1978: 318). The third driver is political vulnerability. For Levine, factors such

as organisational age, size and leadership determine levels of 'fragility and precariousness' and therefore capacity to 'resist budget decrements.' The final category in Levine's scheme is organisational atrophy in which the reduction – real or perceived – in the performance levels of organisations makes them a target for cutback or closure.

Levine understood these causes to be both intertwined and socially mediated, noting that 'retrenchment politics dictate that organisations will respond to decrements with a mix of espoused and operative strategies that are not necessarily consistent' (1978: 319). Research appears to confirm that the 'real' drivers of decommissioning decisions are often disputed, with claims based on problem depletion accused of masking ulterior, cost-cutting motivations (O'Cathain et al. 1999; Giacomini et al. 2000). Levine's typology aids our understanding of the framing of decommissioning plans, which in turn may help investigation of the subsequent unfolding of decommissioning processes (Montini and Graham 2015; Jones et al. 2019).

How services are decommissioned

Levine's work is instructive for understanding *why* decommissioning is attempted and how it might be justified. However, there is currently no general theory that specifically addresses *how* decommissioning of services and organisations unfolds, although insights can be gained from decommissioning case studies and wider literature relating to service change, welfare state retrenchment and policy termination. This section provides a precis of the relevant themes from these literatures to inform subsequent analysis of findings.

Studies of health care decommissioning routinely cite the pluralistic nature of health system contexts, and the resistance and opposition of key actors affected (O'Cathain et al. 1999; Foley et al. 2017). Within public organisations there are a range of semi-autonomous individuals who may dissociate themselves from decommissioning plans (Denis et al., 2007), and the greater the scale of proposed change, the larger the range and number of these 'veto players' (Tsebelis, 2002). In health care, interest groups including medics, politicians, private and public funders and providers often play an important role in contesting decommissioning plans, especially where (for example with doctors and hospitals) they enjoy 'broad public legitimacy' (Jordan, 2011: 118) and/or have a financial interest in service decisions (Rotteveel et al., 2020).

Much attention is therefore given in the service change literature to how such obstacles might be overcome. 'Facts' or 'evidence' are put forward as a counterweight to 'politics' and as a means of shifting attention from partisan self-interest to consideration of service safety, quality and cost effectiveness (Cameron et al. 2007; McHugh et al. 2019). Evidence can be mobilised at multiple decision making stages including: generating acceptance of a problem's existence; setting the terms through which policy solutions should be judged, and; justifying selection of a preferred course of action. In support of decommissioning, evidence is often organised around a 'clinical case' albeit circumscribed by an underlying commitment to broader (and less explicitly evidence-based) policy trends towards service specialisation, centralisation and resource maximisation (Jones and Exworthy, 2015).

Prescriptions for enacting decommissioning invariably promote evidence as means of de-politicising the process. Change leaders (or decommissioning 'agents') are further exhorted to deploy their personal and social resources to generate buy-in from system actors, and to engage audiences in the wider political and public spheres (Norton and Chambers, 2020). This necessitates 'political skills' including: reading people and situations; scanning context, and; building alliances where interests and motives diverge (Waring et al., 2018). For substantive change programmes, it is argued, leaders are required at multiple organisational levels so that both formal, hierarchical authority and informal, distributed influence can be brought to bear (Turner et al., 2016). These prescriptions, drawing on principles of engagement, local knowledge, evidence, persuasion and alliance building, have been crystallised in advice distilled from surveys of the empirical literature (Best et al., 2012) and of decommissioning 'experts' (Robert et al., 2014). The logic is that a negative tipping point can be reached whereby support for change/decommissioning reaches a critical mass, and implementation follows (Rogers, 2003).

In complex organisational processes it is difficult to assess the success or otherwise of such strategies in reconciling the divergent goals, competing rationalities and conflicting interests that affect receptiveness to change (Fredriksson et al., 2019). However, the risk is that emphasis on interpersonal processes leaves the institutional constraints on decommissioning under-explored (Adam and Bauer, 2018). For example, studies in the policy termination literature suggest that, as well as anti-decommissioning actors and coalitions, structural factors can increase path

dependence which in turn precludes decommissioning (DeLeon, 1978). These factors include legal obstacles, costs of ceasing or switching services, and the levers of power available to those initiating the change. The scope for 'change-entrepreneurs' to reverse the effects of such factors can be highly circumscribed (Castel and Friedberg, 2010: 323).

It has been further argued that such characterisations of leader roles and behaviours often obscure their more manipulative forms, and that the strategic manoeuvring required for service termination may exacerbate pre-existing disparities (Wenzelberger, 2011). Fraser et al. (2017) question whether the exercising of managerial power – through discursive strategies (e.g. 'evidence'), tightly managed consultation processes, and new public management tropes of standard-setting and performance measurement - should be understood as 'success' in the redesigning of public services. And to these characterisations of evidence based policy as techniques of power can be added other critical understandings of strategic practices. For example, the welfare retrenchment literature documents more unscrupulous practices of: obfuscation (denying the realities of service cuts); circumvention (of legitimate interests), and; blame avoidance (Pierson 1994; Starke 2006).

Research design and methods

The research reported here followed a comparative case study design across multiple study sites. Case study identification and recruitment drew on contacts established in prior stages of the research – including a national survey of decommissioning in the English NHS - and networks of the research team and advisory group (*authors, anonymized*). From this prior research, we purposefully selected three cases of planned and explicit approaches to decommissioning in the English NHS (see Box 1). These were intentionally heterogeneous, differing by scale, complexity, stage of development, and location, to allow for multiple insights to be obtained (Van de ven and Poole, 1990). In each case, and as is typical of health planning in an English context, decommissioning was instigated by public, unelected bodies, with delegated or devolved responsibilities for budgets and services.

Box 1: Summary of case studies

Case study one. Reorganisation of specialist services for paediatric burn care in England

This case study was selected to fulfil the criteria of being a nationally led reorganisation process involving planned service changes, and at roughly midway between initiation and implementation. It was identified through a mapping exercise (*authors, anonymized*) and access was negotiated via the lead organisation, NHS England. The reorganisation was intended to incorporate the decommissioning, by downgrading, of hospital services. The nature of the proposed decommissioning was therefore service reduction.

Case study two. Reorganisation of primary and acute care services

This case study was selected to fulfil the criteria of being relatively high in scale and complexity and at an early stage of initiation. The site approached the research team having become aware of the research project, and access was negotiated with the programme manager for the service transformation programme. The process had reached the point of appraising options for decommissioning at the start of data collection. The nature of the proposed decommissioning was service removal and replacement.

Case study three. Decommissioning of an end of life home support service

This case study was selected to fulfil the criteria of being locally led, relatively small in scale and complexity, and at the implementation stage. It was identified initially through networks of the research team and access was negotiated with the manager of the decommissioning process. At the commencement of fieldwork, the proposed decommissioning had been agreed and was due to be implemented. The nature of the proposed decommissioning was service removal.

Following site recruitment, a lead investigator (*authors, anonymized*) was assigned to each case study. All case studies involved retrospective and prospective data collection, and this initially focussed on establishing case histories and background information (Van de ven and Poole, 1990). Researchers were experienced in qualitative case study methods and no prior relationships existed between the research team and the sites involved. Early interviews were with decommissioning programme leads, and the subsequent sample was broadened to include managers, clinicians, and public representatives involved in the decommissioning programme. Some of these individuals were pre-identified and others identified through snowballing during data collection. They were engaged initially through the local site contact.

Initial semi-structured interviews explored the reasons for decommissioning and the processes involved in its attempted implementation, using a pre-designed topic guide. A second round of interviews was conducted after approximately 12 months and we

observed all relevant events and meetings known to the research team, taking detailed field notes. Non-participant observations were performed in case studies one and two. These typically included programme board meetings but also meetings such as public consultation events in case study two. Interviewees and those observed were made aware of the aims and focus of the research and its intended outputs. No observations took place in case study three as the decommissioning was at the implementation stage by the time fieldwork commenced.

In total, 49 interviews and 14 observations were carried out across the three case studies (see Table 1) and all available documents were analysed. Only a very small number of individuals declined to be interviewed, in each case citing lack of time. A combination of face-to-face and telephone interviews was conducted according to the preference of interviewees. Observation took the form of contemporaneous note-taking by the lead researcher for each case study and subsequent incorporation of notes into the wider dataset. The final interview sample included 25 individuals in predominantly managerial roles, 10 in predominantly clinical roles (with a higher proportion of these in case study one) and four included as patient representatives/specialists.

Table 1. Case study interviews and observations

Case study	Number of interviews/ interviewees	Number of observations
1. Reorganisation of specialist services for paediatric burn care in England	17/13	3
2. Reorganisation of primary and acute care services	19/13	11
3. Decommissioning of an end of life home support service	13/13	0
Total	49/39	14

Interviews were fully transcribed and coding software (NVIVO Version 11) used to assist with storage and retrieval during analysis. The comparative case study design enabled us to map the multiple interacting actors and influences, and to generalise theoretically from both within and between cases (Yin, 1999). We used our interview topic guide as an initial coding framework. Data were subject to multiple-track coding in order to simultaneously:

- compile a timeline of events
- explore processes, and
- gather data on the views and experiences of those involved

Each case was analysed separately before common themes were identified using cross-case pattern-matching (Eisenhardt, 1989). At this stage, categories derived from the literature were overlaid onto the coding frames to aid analysis of decommissioning causes and processes. These coding frames for qualitative data were refined through 'analysis days' attended by the whole research team. During the research we continually re-examined data, searching for alternative readings of the phenomena we observed (Pettigrew, 1990).

Draft reports were shared with respondents and checked for accuracy with clinical experts before being combined into a final paper. Selected verbatim quotes are included here to illustrate aspects of the findings. All individuals were anonymised and two sites were also anonymised at the request of respondents. Ethical clearance in relation to all aspects of data collection and storage was obtained from the University of Birmingham (ERN_13-0172). Project meetings involved regular discussion of ethical issues and challenges, including informed consent, anonymity and relationships between researchers and participants.

The data that support the findings of this study are available on request from the corresponding author. These are not publicly available due to their containing information that could compromise the privacy of research participants.

Findings

In only one of the three case studies did the intended decommissioning come to pass, with the other two characterised by frustration and delay. In this section we report findings from each case study focussing on the espoused drivers of decommissioning and the processes for putting decommissioning plans into practice.

Case study one: reorganisation of specialist services for paediatric burn care in England

Despite reduced demand and numerous attempts at reorganisation, paediatric burn care provision in large parts of England remains substantially unchanged since the 2001 national Burn Care Review. We followed the work of the Burn Care Clinical

Reference Group (CRG), comprising Burns Care experts and other stakeholders, as it sought to advise the NHS in England on concentrating intensive paediatric burn care into fewer provider organisations. Those advocating decommissioning cited the need to maintain skill levels in the face of reduced patient numbers, as well as the requirement for compliance with standards, which included co-location with a paediatric intensive care unit (PICU). At the time of the commencement of fieldwork, one hospital ('Hospital A') had self-assessed as being in derogation of these standards, and assessment of others was underway. The CRG was also in the process of preparing options for the wider reconfiguration of services into a smaller number of intensive providers. The target completion date for both processes was March 2015. However, by fieldwork completion (May 2016), the process had stalled.

Box 2. Key developments in reorganisation of paediatric burn care services in England

2001 National Burn Care Review
2003 National Burn Care Group set up and secures statutory funding
2004-5 Services first measured against Burn Care Standards
2008-2011 Standards revised and reorganisation processes attempted but not implemented in all regions
2012-13 Creation of NHS England and the Burn Care Clinical Reference Group (CRG) replacing previous National Network for Burn Care. National contract replaces regional arrangements
2013 Standards revised and new service specifications used to carry out an NHS England review of compliance
2014 Non-compliant services considered for derogation
2015 Options put forward by the CRG for the reorganisation of paediatric services
2016 NHS England merges the Burn Care CRG with larger specialities

The case for decommissioning

The 'problem' that decommissioning was intended to solve rested on the premise that levels of supply were unsustainable due to problem depletion resulting from reduced incidence of severe burns. Over an extended period, the evidence for problem depletion had become largely accepted, and the CRG found itself at the nucleus of an organisational and professional network that had been successfully enlisted into the task of responding to this change. Dissent from this position was rare in interviews.

'We've got too many providers as it is. The expertise is far too widely spread, particularly for children. Expertise is used very, very infrequently in some places.' (Interviewee 1: local commissioner and area team representative)

As well as problem depletion, requirements for co-location with a PICU placed at least one organisation in a position of organisational atrophy. However, meeting observations and interviews with those involved indicated far less consensus on this point, and disquiet was voiced at the proposal that that some burn care providers would be 'downgraded.' Much of this discord centred on Hospital A, which many interviewees sought to defend.

'Strictly speaking I shouldn't even be allowed to manage a burn that's two per cent on the hand. But if you look at my healing times, if you look at my complication rates, if you look at my patient satisfaction, if you look at the functional outcome of the patients that I treat, curiously enough they're as good as, if not better than, most of my colleagues who work in the services which tick all the boxes.' (Interviewee 3: burns consultant/CRG member)

Those seeking to challenge claims of organisational underperformance targeted flaws in the evidence base behind the standards and there was an acknowledged paucity of independent research into burns services, a function in part of small patient numbers and the low service profile. This was compounded by an absence of national clinical guidance or synthesis of the international evidence base.

'We're in the development of the reporting stage and gathering the evidence as a case for change. That has been an incredibly painful process in terms of seeking a consensus on the evidence base, which is very limited.' (Interviewee 11: NHS England Programme Team representative)

Those seeking to defend Hospital A identified political vulnerability as the unspoken driver of the proposed downgrading:

'They're all big institutions, teaching hospitals, strongly supported by their local health economy. We're a little pimple in [name of area] aren't we?' (Interviewee 5: Consultant at hospital A)

To some extent the arguments in favour of decommissioning also rested on assertions of environmental entropy, i.e. the need to maximise scarce NHS resources. However, many decommissioning agents believed the projected financial savings were not considered by central NHS bodies to be sufficient to warrant the investment required for implementation.

'We [burns services] are too small. They're keen to centralise other services because they cost a shed load. They're a significant slice of the financial NHS pie whereas we aren't. We are never going to make a financial hole in anybody in which case we're below the event horizon as far as they're concerned' (Interviewee 10: burns consultant/CRG member)

Rates of progress

As the evidence was contested, the decommissioning project was heavily reliant on leadership tools of persuasion and exhortation. However the consensus ultimately proved to be somewhat brittle in the face of structural changes in the wider context. Ultimately, the inability of the CRG to either override local opposition or engender central support appeared to lead to stalemate, and the decommissioning plans drawn up were not implemented during the lifetime of the study. In interviews and during observations, CRG members increasingly lamented the lack of levers for mobilisation, and the influence of external political and financial imperatives:

'Timing is critical: don't try and do anything that could be controversial in a period leading up to a general election.' (Interviewee 4: patient representative/former CRG member)

'You can't make changes, you know, real changes without dosh and there ain't none at the moment.' (Interviewee 6: senior burns nurse)

Towards the end of the case study the future of the network itself was in question, as NHS England overhauled its CRG structure, and this fuelled cynicism over the plans.

'I've been involved in burn care planning ... particularly with regards to paediatric care, for 15 years. Nothing has changed. I've got reports in my office somewhere from the 1990s about reorganisation of burn care and we're still – in fact guess what we're having next year? Another review of paediatric burn care.' (Interviewee 5: consultant at hospital A)

Ultimately, the experience of the paediatric burn care reorganisation suggests that the energy and resources expended were ultimately insufficient to enable implementation. Crucial in this appeared to be the resilience of provider organisations in the face of the proposed cutbacks, and an apparently unsupportive or indifferent wider political and structural context. There was a notable lack of formal authority in the face of

opposition, and Hospital A – despite protestations to the contrary – proved invulnerable to the proposed decommissioning.

Case study two: reorganisation of primary and acute care services

Case study two involved a major reorganisation of local health care provision including specific plans to ‘centralise’ emergency care into a single site, thereby decommissioning services from another hospital. The reorganisation was led by a NHS Clinical Commissioning Group (CCG) (a local NHS planning body) which at the time of fieldwork was made up largely of new appointees, and covered an area with a population of approximately 600,000. In the summer of 2014, the CCG announced plans for a strategic review ahead of a reorganisation of primary and acute care.

Box 3. Timeline for the case study of the reorganisation of primary and acute care services

September 2014	Appointment of external consultants to advise on the review and appointment of the programme manager
November 2014	Official launch of the review
Winter 2014	Building the ‘case for change’, data gathering, stakeholder meetings and engagement
March 2015	Launch of the interim ‘need for change’ document
May 2015	Reflection and analysis (purdah period to coincide with a general election)
July 2015	Launch of the final ‘case for change’ and options for decommissioning
Autumn 2015	Public engagement on options for decommissioning
Winter 2015 – Spring 2016	Decision making and plans for implementation

The case for decommissioning

The case for decommissioning was dominated by long-standing financial and estates deficits in one hospital trust where one third of the sites had been designated unsuitable and/or were unoccupied, and were incurring a significant debt and maintenance backlog. Other organisations within the area, including community and mental health services, were also projecting significant challenges in response to demographic and financial pressures. The rationale therefore rested primarily on threats to the financial viability of services (environmental entropy) with projected long term damage to service quality (organisational atrophy).

‘If the patch continued to operate as it currently did, it wouldn’t be delivering the best outcomes to the local population and along that journey, on a kind of two

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3 *to five year basis, some of those organisations were going ... to struggle to be*
4 *sustainable.’ (Interviewee 28: CCG senior officer)*
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7 This financial context formed the primary frame through which the CCG advocated
8 decommissioning, who then sought to compile an evidence-based clinical ‘case for
9 change’. This appeared to have been successful inasmuch as, following intensive
10 lobbying from the CCG, the local provider organisations acquiesced on the central
11 case for decommissioning.
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16 *‘The stakeholder management bit is something I’ve spent probably 60% of my*
17 *time on, making sure that people feel as if they’re connected into it and*
18 *understand where it’s getting to, what it’s doing. So that we don’t get to a point*
19 *in the summer or the autumn where people say ‘You’ve been doing this in the*
20 *bubble, I don’t recognise it and I’m going to snooker it.’ (Interview 1: programme*
21 *manager)*
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27 This involved heavy investment in evidence collection and management support, all
28 with the primary aim of increasing stakeholder ‘buy in’, and overall this was the most
29 resource intensive of the three case studies. The initial plan was for a 12-week review
30 and consultation period whereby an external management consultant would produce
31 reorganisation proposals and a programme manager, seconded from another part of
32 the NHS, would co-ordinate the review. During the period of data collection, this was
33 revised to a much longer review and consultation period (18 months), now involving
34 two external consultancies: one to provide expert advice and another to lead the
35 communications and public engagement work. This change was reportedly due to
36 concerns over the feasibility of a 12-week period, as well as the legacy of several
37 previous controversial and unsuccessful attempts to reorganise acute services in the
38 area.
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48 *Rates of progress*

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50 In July 2015, three decommissioning options were proposed, including a new hospital
51 build in a central location and centralisation of acute services at either one of two
52 existing sites. Following previously unsuccessful attempts at reorganisation, multiple
53 methods were employed to engage patients and the public in the process and to
54 maximise the visibility and credibility of the work. Considerable time was also spent
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developing a 'vision' and accompanying governance structure to increase a 'shared sense of ownership' amongst the organisations affected.

In these ways, those leading the decommissioning indicated a tacit awareness and acceptance of the limits to their authority and power. Repeated references to the imperative to create buy in and a sense of ownership indicated a reliance on non-coercive methods in a context of locally powerful organisational actors. Whilst this approach engendered some agreement regarding the need for change, including amongst patient representatives attending consultation events, adding detail to the general decommissioning intention proved contentious. Tensions increased as the potential consequences for individuals and organisations became clear.

'So, this is about the chickens coming home to roost I think and everybody is thinking this will be alright for them, it's everybody else that's going to have to give. There's going to have to be some give and that's the only way around it.'
(Interviewee 32: acute trust director)

Despite borrowing methods from prior reconfiguration programmes in the NHS, including expensive and somewhat elaborate processes of option appraisal, consultation and engagement, the plans had stalled by the time fieldwork ceased in June 2016. This was in part due to failure to agree to the specific changes required for implementation and, as with Hospital A in case study one, the absence of a mechanism to force through changes to the perceived detriment of local organisations. This was further complicated by the scale of the plans.

'I think the biggest challenge to this programme is its broad scope. They were very ambitious in saying 'let's put everything on the table' so this is about prevention, it's about self-care, it's about voluntary sector, it's about community support, it's about acute, it's about specialist services. And whilst that is helpful, because it makes it holistic and you can come at it with a strategic overview and it probably has a better resonance with communities, it makes it much more complex to mobilise.' (Interviewee 33: partnership trust director)

Ultimately, the rate of progress slowed to a point where interviewees expressed concern as to the increasing inevitability of implementation failure.

Case study three: Decommissioning of an end of life home support service

Case study three involved the planned decommissioning of a charity end of life (EOL) home support service which provided non-clinical support to patients, their families and carers. The service comprised a named nurse co-ordinator who provided regular contact and home visits, alongside telephone access to a 'care bureau' providing triaging and 24-hour nursing advice and support. The service aimed to increase the percentage of patients dying in their preferred place of death, improve support for carers, and reduce unnecessary admissions to hospital. It had been funded by the NHS since 2009 with the contract due to expire at the time of fieldwork. In October 2013, a six month contract extension for existing patients was agreed to enable a review of the service, and this was followed by a three-month managed closure process beginning in April 2014. This was the only one of the three decommissioning case studies to proceed to full implementation during the lifetime of the research project and therefore something of a 'positive outlier' both within the sample and the wider literature (Flyvbjerg, 2006).

Box 4. Timeline for case study of the decommissioning of an end of life home support service

Summer 2013 Plans for the review of the EOL Home Support Service announced
October 2013 Six month extension to the service contract agreed in order to carry out the review
Oct 2013–March 2014 review undertaken
March 2014 Review document published and presented to decision-makers, three month extension to the service contract agreed to manage the close down of the service
April 2014 Close down and discharge of patients from the service begins

The case for decommissioning

Decommissioning was again initiated by the local CCG, on grounds of organisational atrophy (i.e. relating to the effectiveness of the service in meeting its targets), and environmental entropy (reflecting the financial constraints on the CCG).

Unlike case study one, the group assembled to progress the plans was narrowly constituted; the CCG made up the core of the review team, and the CCG identified and appointed a clinician to act as the figurehead. The review team collected a range of evidence including data on service outcomes and the CCG's own cost per patient estimates. These were combined with results from surveys of both patients/service users and referring GPs. Following these activities, the review team concluded that the service should be decommissioned on the following grounds:

- significant numbers of service users did not meet the specification of being at end of life
- significant areas of overlap existed with other services
- the EOL service did not achieve its performance target in relation to reduction of hospital admissions

The evidence collected by the CCG was equivocal. For example, identified shortfalls in service outcomes were at odds with survey results indicating positive assessments of the service from service users, carers and some GPs.

‘The service is generally liked by GPs as it does provide a further source of support for certain patients. Results from practices in [name of area], the largest users of the service, were equivocal about its value. However multiple practices highlighted the benefit of additional support for dementia patients and their carers.’ (Review document)

The CCG themselves acknowledged uncertainty in the evidence informing the decision:

‘We had to make some broad assumptions around that ... we couldn’t actually say what impact [the decommissioning] would have, other than wait and see what happens after six months.’ (Interviewee 18: CCG Commissioner)

Rates of progress

Implementation of the review conclusions was nearing completion at the time of fieldwork and seems to have encountered relatively little resistance. During the review process, the leadership activities displayed were more targetted than for the other case studies and took the form of active co-option of referring GP practices, as this was the professional group most affected by the proposed changes. Perhaps most remarkable and decisive in the outcome was the acquiescence of the decommissioned service provider, who was described by the CCG as being ‘helpful in the process, even if they recognised they were sort of arranging their own funeral.’

‘In the end I think we just took a reasonably pragmatic view which is that we know that the quality of the services we provided has been of very high standard [but] the decision had been made and I think it would have been churlish to challenge the decision of the CCG. You know, we didn’t want to be

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3 *confrontational about this.’ (Interviewee 26: senior staff member at EOL*
4 *service)*
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7 This compliance had the effect of shielding the CCG from direct expressions of service
8 user disaffection. Instead, provider staff described having to conduct difficult
9 conversations with patients aggrieved about the closure, as well as carer complaints
10 about the loss of support.
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14 Overall, the process was relatively tightly managed and drew on fewer individuals and
15 less resource than for other case studies. CCG interviewees emphasized the evolving
16 nature of the implementation process, and the lack of formal guidance or template for
17 its management.
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22 *‘We did a pretty good job. There wasn’t much to go on. We had to kind of feel*
23 *our way through it. We only had a skeleton structure ... We kind of used*
24 *common-sense and just general project management skills to kind of get*
25 *through it.’ (Interview 15: delivery officer)*
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29 Overall there was little to suggest any elaborate strategies or complex social
30 processes in this example, perhaps reflecting the somewhat narrower focus of the
31 decommissioning plans. Implementation was enacted not only in spite of the
32 misgivings of those actors (both professional and patient) implicated in the decisions,
33 but in the case of the provider organisation, implementation actually depended on their
34 active consent. Despite the claims made concerning drivers (i.e. environmental
35 entropy and organisational atrophy) perhaps the most important predictor of
36 implementation in this case was the *political vulnerability* of the organisation in
37 question, not to mention the patient group affected. In comparison to the organisations
38 in the prior case studies, the EOL service was vulnerable to, and ultimately compliant
39 with, its own decommissioning, and the institutional levers were favourable to the
40 proposed change.
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50 Despite this, the subsequent implementation phase encountered unforeseen
51 problems and concerns about alternative service access for the patient group led to
52 an extension of the discharge timeline. Although the decision to decommission the
53 EOL service was not contested at the time, subsequent interviews with provider staff
54 revealed mixed feelings over drivers and timelines for the process, as well as cynicism
55 as to the role of patient survey data in the decommissioning decision.
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Discussion and conclusions

This study confirms that decommissioning is a contentious area of service planning and change, and one that it is often not difficult to oppose (Oborn, 2008). Each of the three case study processes was initiated through the articulation and framing of a problem, for which decommissioning was presented as the only credible solution, and advocates sought to mobilise evidence in support of this ‘case for change’. For the burn care review, this case had been painstakingly compiled over many years, and similarly the local hospital reconfiguration included a large amount of evidentiary documentation in support of the proposals. Decommissioning agents also pursued other avenues of persuasion and influence, for example through co-option of system actors onto formal bodies and initiation of wider consultative exercises. However, in both examples these activities were insufficient to dislodge the targetted services, as both the alliances in the burn care reorganisation and commitment to the local reorganisation proved brittle in the face of real decrements to the organisations involved.

By contrast, the CCG in case study three invested only lightly in the case for change and were able to overcome opposition from stakeholders. Plans were implemented by a tightly controlled network of actors, acting on modest evidence and a highly bounded engagement process. The distinctiveness of this experience is clearly in part attributable to the modest scale and complexity of the plans, which helped circumvent the political and institutional forces that impeded the burn care review, and the organisational entanglements that crippled the local service reconfiguration.

In contrast to studies reported elsewhere, the role of the public was not significant in determining the outcomes in any of the three case studies (Foley et al., 2017). One distinguishing characteristic of the only case to be ‘successfully’ decommissioned was the political vulnerability of the implicated provider organisation, in contrast to the hospitals in cases one and two. This would appear to support the longstanding (but sometimes overlooked) claim that institutional design and longevity affect levels of vulnerability/resilience to decommissioning (Greasley and Hanratty 2016; Boin et al. 2010). Somewhat paradoxically, the NHS hospitals proved more capable of resisting reorganisation, whereas defence of the external contracted provider was easily overcome.

Also important to case three was the ready availability of an implementation mechanism (in the form of a simple two-party contract) which meant that enactment of the policy was relatively simple, despite subsequent concerns about efficacy and equity of the transition and its outcomes. Under these circumstances, decommissioning became more akin to a managerial procedure than a complex change process. This suggests that prior levels of – using Levine’s terminology – political vulnerability are a possible predictor of subsequent implementation in decommissioning (see Table 2). Although this was never formally acknowledged by decommissioning agents, it was perhaps tacitly recognised by the strategies adopted in each case, and the level of investment in activities designed to ‘win over’ potentially oppositional stakeholders.

Table 2. Scale, complexity and drivers of decommissioning case studies

Case study progress	Cited drivers	Extent of political vulnerability	Scale and complexity of decommissioning plans
1. Burn care reorganisation, unsuccessfully implemented	Problem depletion Organisational atrophy Environmental entropy	As well-established, NHS service providers, the organisation/s threatened with downgrading proved resilient to proposed changes	The plans were high in: scale, i.e. covering England with implications for other UK nations, and; complexity, i.e. encompassing multiple overlapping organisations and actors
2. Local reorganisation, unsuccessfully implemented	Environmental entropy Organisational atrophy	The acute hospitals implicated in the proposed changes all proved able to resist decrements to their services	Although local in scale, the plans were all-encompassing and highly complex in the number of implicated organisations and actors
3. Decommissioning end of life service, successfully implemented	Organisational atrophy Environmental entropy	As an independent third sector, contracted provider of non-clinical services, the organisation threatened with decommissioning proved vulnerable to the proposed changes	The plans were smaller in scale than the other case studies, i.e. encompassing only one service. Complexity levels were significant as many other actors were potentially implicated in the decision

However, the outcomes observed in each case seemed somewhat independent of the relational and interpersonal skills demonstrated by decommissioning agents. In case studies one and two there was a commitment to a resource-intensive and gradualist approach (albeit accompanied by some pessimism and foreboding) in which it was hoped those most affected would be persuaded to subscribe to the plans. By contrast, and contrary to decommissioning ‘good practice’, in case study three decommissioning actors were able to exclude the provider organisation from the

process until the implementation phase, when they were called upon to help manage patient discontent (Robert et al., 2014).

The fate of the decommissioning plans apparently therefore relied at least as much on the institutional regimes and formal levers of power as they did on the relational skills of decommissioning agents in the face of opposition (Fraser et al., 2017). In case study three, the exercise of managerial power was decisive whereas in case studies one and two it proved insufficient. This is consistent with the claim that decommissioning is most likely to take place incrementally, and within ‘the existing institutional framework’ (Fontana 1988; Starke 2006 p.111). These institutional factors, which may be especially influential in decommissioning where changes are inherently unpopular, created the conditions in which the exercising of organisational self-interest became possible. Linked to this, the case studies revealed a disjuncture between espoused and actual drivers of decommissioning, with the realities of political vulnerability obscured by claims and counter claims relating to problem depletion, organisational atrophy and environmental entropy. Without that prior institutional vulnerability, coalitions of oppositional actors were able to disavow and undermine decommissioning plans once these became concrete; as one of our Burn Care CRG interviewees noted wryly: ‘people will accept the theory until it gets applied to them’.

Acknowledgements

This study/project is funded by the National Institute for Health Research (NIHR) Health Services Delivery Research programme (project 12/5001/25). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

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